

FILED OCT 25 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34174

State File No. _____

Registration District No. 118

Primary Registration District No. 4188

Registrar's No. 67

1. PLACE OF DEATH:

(a) County Gasconade
(b) City or town Owensville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 35 years
years, months or days)

3. (a) PRINT

FULL NAME Henrietta Dieckgraefe

3. (b) If veteran,

name war 2

3. (c) Social Security

No. 4

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
(b) Name of husband or wife Rudolph Dieckgraefe 6. (c) Age of husband or wife if alive dead years
7. Birth date of deceased June 13 1865
(Month) (Day) (Year)

8. AGE: Years 82 Months 3 Days 1 If less than one day
hr. _____ min. _____

9. Birthplace Wooliam Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

12. Name Fredrick Hangstenberg
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Wilhelmina Pohlman
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Leslie Leach
(b) Address Owensville, Mo.

17. (a) Burial Ev. Cem. Owensville, Mo. (b) Date thereof 9 16 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Milford H. H. Winter

18. (a) Signature of funeral director Owensville, Mo.
(b) Address _____

19. (a) 10/2/47 (b) Smith Jackson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade 37
(c) City or town Owensville 2
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 2
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 14
year 1947 hour 4 minute 8 M.

21. I hereby certify that I attended the deceased from Aug 4 1947 to Sept 14 1947
that I last saw her alive on Sept 12 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Senility Duration _____

Due to Fracture of femur
due to fall at home
Due to Owensville, Mo on
Aug 4, 1947.

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 156
Of autopsy 156
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence 37
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Mo

While at work? _____ (Specify type of place) (e) Means of injury 2

23. Signature H. H. Bradley (M. D. or other) 100
Address Owensville Mo Date signed 9-15-47

RECEIVED
District Health Officer No. 2.
District File Number
Date Filed 10-24-47

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Harvey Kalk....., Registered Apprentice No. 9
working under my personal supervision.

Signed Melford H. H. Winter

Licensed Embalmer No. 3838

P. O. Address Queensville Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1102
Registrar's No. 67

Registration District No. 118 Primary Registration District No. 4188

1. PLACE OF DEATH

- (a) County Gosport
(b) City or town Owensville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME

- Henrietta Duckgraff
3. (b) If veteran, name war 3. (c) Social security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced and

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years

7. Birth date of deceased June 15 (Month) (Day) (Year)

8. AGE: Years 82 Months 3 Days 11 (If less than one day) hr. min.

9. Birthplace (City, town, or county) (State or foreign country) Mo

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

- (b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

- (c) Place: burial or cremation

18. (a) Signature of funeral director

- (b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Year 1947 hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from 1947 to 1947, 1947; that I last saw him alive on Aug 4, 1947; and that death occurred on the date and hour stated above. Immediate cause of death: fracture Duration

- Due to

- Due to

- Other conditions (Include pregnancy within 3 months of death)

- Major findings: Of operations

- Of autopsy

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence Aug 4 - 1947
(c) Where did injury occur? Town square Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home

- While at work? yes (Specify type of place) (e) Means of injury fracture

23. Signature H. Bradley (M. D. or other) MD
Address Owensville Mo Date signed 10-28-47

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

34174